VZCZCXRO2375
OO RUEHGI RUEHRN RUEHROV
DE RUEHKM #1098/01 2661257
ZNR UUUUU ZZH
O 231257Z SEP 09
FM AMEMBASSY KAMPALA
TO RUEHC/SECSTATE WASHDC IMMEDIATE 1800
INFO RUEHXR/RWANDA COLLECTIVE IMMEDIATE
RUCNIAD/IGAD COLLECTIVE IMMEDIATE
RUEAUSA/DEPT OF HHS WASHINGTON DC IMMEDIATE
RUEHPH/CDC ATLANTA GA IMMEDIATE

UNCLAS SECTION 01 OF 04 KAMPALA 001098

SENSITIVE BUT UNCLASSIFIED
SIPDIS

FOR AMBASSADOR GOOSBY FROM AMBASSADOR LANIER
DEPARTMENT FOR OGAC AND AF/EX
USAID FOR BUREAU OF GLOBAL HEALTH
HHS/PHS FOR OFFICE OF GLOBAL HEALTH AFFAIRS
CDC FOR GLOBAL HEALTH OFFICE

E.O. 12958: N/A
TAGS: PGOV KHIV SOCI TBIO PHUM EAID UG
SUBJECT: SCENESETTER FOR OGAC AMBASSADOR GOOSBY SEPTEMBER 26-30 VISIT TO UGANDA

SUMMARY

¶1. (SBU) Summary: You are visiting Uganda when the long-running war against the HIV/AIDS pandemic is at a crossroads. Under the leadership of President Yoweri Museveni, Uganda was a pioneer in recognizing and taking tangible action against HIV/AIDS in the 1990s. Prevalence rates plunged from nearly 20 percent then to under seven percent today. But incidence is again on the rise in the context of a rapidly expanding population, and growing complacency, from both the Government of Uganda (GOU) and the population at large. Much of Uganda's success since 2004 is the success of PEPFAR, which began to ramp up that year. But Ugandan complacency is also partly a legacy of PEPFAR. By scaling up so rapidly in response to the emergency, and by largely bypassing GOU entities in the process, we created donor dependence and diminished any incentive for the GOU to lead the way, as it did pre-PEPFAR. Your visit is an opportunity to start changing this dynamic through engaging the leadership on sustainability and the potential offered by a Partnership Framework. We urge you to consider in these discussions the need to re-incentivize Uganda to take ownership of its HIV/AIDS challenge. End Summary.

¶2. (SBU) The U.S. Mission in Uganda looks forward to your visit September 27-30. We believe we have a strong program and we seek your assistance in reinvigorating the national response to HIV/AIDS. Your office asked for a brief response to several questions regarding the next phase of PEPFAR and how it should be operationalized. This cable addresses those questions and outlines some of the challenges we face in Uganda.

INCREASE COUNTRY OWNERSHIP

¶3. (SBU) The GOU has failed to assume responsibility for the HIV/AIDS problem for a number of years. There is a lack of leadership at the highest levels and a sense that health, including HIV/AIDS, is not a national priority, as shown by the GOU's small budget allocations for the health sector. Management at the national level is also weak, which results in a lack of coordination, poor communication of strategies and guidance, and unclear direction.

¶4. (SBU) Corruption: Uganda is ranked 126th out of 180 in the Transparency International Perception of Corruption Index, and its performance is deteriorating. A draft report by the Anti-Corruption Working Group of Uganda in June 2009 found that "Corruption remains a major impediment to development and a barrier to reducing poverty in Uganda," that it is "deeply imbedded, is not reducing, and has

the potential to get worse." "The analysis suggests that there are high impact corruption risks on the immediate horizon" could adversely affect the national benefit from the 2011 election and the revenues from recently discovered oil.

¶5. (SBU) Partnership Framework issues: In April 2009, we wrote to OGAC that "The PEPFAR team in Uganda, with concurrence from the Ambassador, has decided not to request Partnership Framework funds in FY 2009. We do not feel that the Government of Uganda is showing a meaningful commitment to health, or that the Ministry of Health itself is showing leadership and commitment. Recent experiences with the Global Fund, the AIDS Indicator Survey, and the ARV stockout have convinced us that the MOH is not currently a good steward of its existing resources. Putting more money on the table now, before we work out the conditionalities of framework money, would send entirely the wrong signal to the Government at this time. We need to have careful negotiations regarding our existing partnership with the Government of Uganda before we expand that to a full Partnership Framework. This will probably take a year; we certainly would not be able to conclude these negotiations in time to submit requests for FY 2009 funds." The GOU's failure to show leadership and commitment to improving health, fighting corruption, and utilization of resources has not changed our position.

¶6. (SBU) One positive step in building national ownership of the HIV/AIDS program has been the recent change in the governance of PEPFAR activities in Uganda. For the first five years of PEPFAR, an ad hoc PEPFAR Advisory Committee, appointed by the Office of the President, advised the USG to ensure that the PEPFAR program was complementary to other HIV/AIDS programs, operated under the National Strategic Plan for HIV/AIDS, and was supportive of Ugandan policies. At the last meeting of the Committee, it was decided that

a Partnership Committee (a GOU multisectoral HIV/AIDS committee charged with coordinating the HIV response in the country) could provide better oversight. Members of this committee also sit on the Global Fund Country Coordinating Mechanism.

EXPAND SUSTAINABILITY

¶7. (SBU) The presence of strong local NGOs working in HIV/AIDS is also a positive factor. For example, In FY 2009 The AIDS Support Organization (TASO) was the second largest recipient of PEPFAR funds, due to its strengths as a service delivery organization. TASO, founded in 1987, now has 11 service centers and 22 smaller facilities throughout Uganda. At the end of FY 2008, TASO was providing direct ART treatment to 23,000 Ugandans. It was recently awarded the contract to be the second Principal Recipient in Uganda for the Global Fund. The third largest recipient of PEPFAR support in 2009 is the Mulago Mbarara Teaching Hospitals' Joint AIDS Program (MJAP). This collaborative partnership between Makerere University Faculty of Medicine, Mbarara University Faculty of Medicine, Mulago Hospital and Mbarara Hospital was established in 2004. It provided ART services to 16,000 people at the end of FY 2008. The Joint Clinical Research Center (JCRC) is another outstanding NGO. Founded in 1991 at the height of the AIDS crisis in Uganda to serve as a national AIDS research center, JCRC has become Uganda's pioneer center of excellence for AIDS care, treatment, research, and training. With PEPFAR funding, JCRC was providing direct ART treatment to 40,000 people at the end of 2008, and referral laboratory services throughout Uganda.

IMPROVE INTEGRATION

¶8. (SBU) Given the broad strengths that exist in USAID and CDC, we will be able to coordinate HIV/AIDS activities with other USG health initiatives during the next phase of PEPFAR. USAID and CDC jointly participate in the President's Malaria Initiative, which already has links with the PEPFAR care program. With USAID's experience and funding in reproductive and child health and family planning, and CDC's experience and funding in emerging infectious diseases, the

U.S. Mission is poised to expand the integration of health activities in Uganda.

¶9. (SBU) There is a strong AIDS Development Partner group made up of multilateral agencies (e.g., UNAIDS, UNICEF, WHO, UNFPA) and bilateral donors (e.g., USG, DFID, Irish Aid, DANIDA, Italian Cooperation). It meets monthly to share information, and works to coordinate a common, integrated response to the HIV/AIDS epidemic. Its major activity is to harmonize and coordinate those donors working in HIV/AIDS to provide better support and oversight of the Uganda AIDS Commission, which several of its members fund. Integration and coordination with the broader Health Development Partners group, however, could be improved.

IDENTIFY AND DEVELOP EFFICIENCIES

¶10. (SBU) Costing studies: The USG conducted costing studies for HIV treatment programs in Uganda (pre-ART and ART) for a five year period using the PEPFAR ART Costing Project Model. The MOH, in partnership with Supply Chain Management Systems (SCMS), also carried out national four-year (2009-12) ARV drug quantification to determine country needs. The results are being utilized to ensure more realistic, standardized, and efficient targeting, resource allocation and tracking in the future. This will also assist the GOU/MOH and stakeholders to mobilize required resources for care and treatment given the current funding situation. Similar costing studies in other areas (e.g., orphans and vulnerable children, PMTCT) are being planned.

¶11. (SBU) As the PEPFAR Uganda program moves into PEPFAR II, the USG team is reviewing its portfolio to build upon previous progress and develop a strategic plan for HIV/AIDS treatment. This review is a collaborative effort comprising the MOH, USG agencies and partners, and consultants from the OGAC Adult Treatment Technical Workgroup. The purpose of the assessment is to help the USG in-country team develop a vision for the HIV care and treatment program over the next 3-5 years, and to consult with participants to develop 8-12 recommendations that are essential or very important to

achieving the vision. The overarching issue is that as demand for ART outstrips supply and PEPFAR country budgets remain flat, the team needs to understand the clinical, programmatic and financial dynamics of its ART programs.

PROGRAM MANAGEMENT
(BOTH USG AND PARTNER COUNTRY)

¶12. (SBU) The U.S. Mission is shifting its emphasis from the emergency nature of the first phase of PEPFAR to one of making the necessary investments in systems, infrastructure, and national leadership and management that will enable Ugandans to take on increasing ownership of health care in their country. We need assistance from Ambassador Goosby and others in inspiring senior GOU officials to again assume the leadership of the fight against HIV/AIDS.

¶13. (SBU) We believe that OGAC itself needs to change to meet the needs of the next phase of PEPFAR. As Ambassador Browning said in his COP transmittal letter in 2008, "As we shift responsibility and trust to our national partners, we believe OGAC will likewise have to adjust to a new way of doing business. OGAC structures that were perhaps needed for an emergency response will ideally devolve responsibilities to the field and make do with less detailed reporting. For example, as we move towards a Ugandan-owned program, OGAC's twenty technical working groups, committees, and task forces, made up of 500 experts, cannot expect to be able to make the same requests for information to Ministries of Health that they now make to Mission staff." For a Partnership Framework to have any chance of incentivizing the GOU to take greater ownership of the HIV/AIDS challenge, OGAC may also need to consider more direct forms of support to GOU entities, in exchange for the GOU meeting simple and

realistic performance benchmarks. A program that continues to provide resources directly to implementing partners on the ground, bypassing the GOU as is largely the case now, has little chance of inspiring and incentivizing GOU leadership and ownership.

IMPLEMENTATION

¶14. (SBU) Rationalize care and treatment services: There is need for improved coordination of services at all levels USG, MOH, districts, and facility. We will employ a number of strategies in FY 2010 to accomplish this. First, we will reduce duplication. The USG will focus on mapping care and treatment services by partner and program area and work with the GOU/ MOH to minimize overlap and maximize efficiencies. Second, we will advocate for support to district-based programs that work in close partnership with the district health management. Such support will promote integration and improve alignment in planning, implementation and monitoring of services in the district. USG district support will include activities such as conducting situational analyses to guide prioritization of implemented activities, providing annual performance-based conditional grants to districts, mainstreaming HIV/AIDS into district work plans, aligning reporting with national requirements, improving data quality, availability and utilization, and improving technical support supervision for ongoing activities. Third, we will continue to expand program implementation through indigenous NGOs and the public sector.

TECHNICAL SKILLS/
HUMAN RESOURCES FOR HEALTH

¶15. (SBU) A national training strategy does not currently exist. While the USG plans to train at least 400 new health workers in FY 2010, future targets will be developed via a national training strategy, and building institutional training capacity and performance in FY2010. A new mechanism will be established to work with the Ministry of Education and Sports, the MOH, and professional councils to develop a national training strategy and plan, and to establish national, standardized curricula and certification schemes for all cadres of health workers. Support to build local capacity and promote standardization will be provided directly to indigenous training institutions, instead of to international organizations.
¶16. (SBU) To support recruitment and retention of staff in health facilities, the USG plans to continue its support for the finalization of a national retention and motivation strategy, and

continue to provide technical assistance to districts to improve their recruitment efforts. Scholarships and bonding schemes will be developed for recruiting and retaining health workers in public sector facilities. While these efforts are expected to improve recruitment and retention, progress will be limited primarily by inadequate funding for direct recruitment and retention activities.

¶17. (SBU) While there has been an increased focus and investment in strengthening human resources for health (HRH) at the national level, the GOU's overall leadership and investment for routine HRH policy, planning, management and monitoring remains weak. This is especially true at the subnational level, where HRH staff and resources are scarce. HRH management is poor, with almost non-existent performance management and disciplinary action. The GOU's administrative capacity and political and financial commitment does not currently appear to be sufficient to lead the development and management of complex HRH schemes, such as performance-based financing. The development of a task shifting policy has been delayed due to the inability of the various line ministries and professional societies to coordinate and reach consensus on appropriate tasks, training, supervision and remuneration.

HEALTH SYSTEMS STRENGTHENING

¶18. (SBU) PEPFAR funds for focused interventions in Health Systems Strengthening (HSS) are largely in the areas of human resources for health (HRH), health information systems (HIS), leadership/governance (L/G) and supply chain management (SCM). There is less emphasis in the area of health finance (HF). Both L/G and HF also receive substantial support through other USG and non-USG donor mechanisms which have greater competitive advantage. PEPFAR Uganda also tries to maximize intentional spillovers of non-HSS focused activities to strengthen health systems. Finally, the PEPFAR team actively leverages efforts to strengthen all national systems that impact on health through relevant national coordinating and technical bodies, such as the Health Policy Advisory Committee, the Uganda AIDS Commission, the Health Development Partners and the AIDS Development Partners.

POINTS TO MAKE AND CONSIDER FOR YOUR VISIT

¶19. (SBU) During your visit here, and in your meetings with the Ugandan leadership and the HIV/AIDS community, we suggest that you emphasize the following themes:

--Fighting HIV/AIDS is one of the strongest elements of our overall bilateral relationship.

--The U.S. remains committed to supporting the GOU and the Ugandan people in preventing HIV/AIDS, and in caring for and treating those who are HIV-positive.

--But we can't do it alone; partnership is a two-way street that by definition requires mutual commitment and accountability.

--Ultimately, managing the pandemic is a Ugandan responsibility.

--As we move away from the emergency phase of our PEPFAR program, we need to create sustainability by strengthening health systems and human capacity in Uganda.

--Through a Partnership Framework, the U.S. is able to provide additional funding for building sustainability.

--Moving forward with a Partnership Framework will require stronger Ugandan ownership of the HIV/AIDS challenge, and more focused leadership from Ugandan leaders at all levels of government.

LANIER